		I AND HUMAN SERVICES & MEDICAID SERVICES	405	CA 5 2011	FORM	M APPROVED D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		445264	B. WING _		11/	30/2011
NAME OF	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
LAUGH	LIN HEALTH CARE CE	ENTER		01 E MCKEE ST GREENEVILLE, TN 37743		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF T	ULD BE	(X5) COMPLETION DATE
	An annual Recertif investigation #2818 November 28-30, 2 Center. No deficier complaint investigat Part 483, Requirem Facilities. 483.20(g) - (j) ASSE ACCURACY/COOR The assessment more reach assessment with participation of health A registered nurse massessment is completed in a session of the assessment must signature to a civil more \$1,000 for each assessment in a subject to a civil more \$1,000 for each assessment penalty of not more transport to a civil more transport to a civil more transport to a civil more \$1,000 for each assessment penalty of not more transport to a civil more transport transport to a civil more transport transport to a civil more transport transport transport transport transport transport transport transport tran	ication survey and complaint 2 were completed on 011, at Laughlin Health Care ncies were cited related to tion #28182 under 42 CFR ents for Long Term Care  ESSMENT EDINATION/CERTIFIED ust accurately reflect the nust conduct or coordinate ith the appropriate ith professionals.  Inst sign and certify that the pleted.  Completes a portion of the gn and certify the accuracy of seesment.  Medicaid, an individual who by certifies a material and resident assessment is ney penalty of not more than essment; or an individual who by causes another individual and false statement in a it is subject to a civil money han \$5,000 for each	F 278	Laughlin Healthcare Center acknowledges that during the A Recertification Survey and Com Investigation #28182, complete November 28-30, 2011, no deficiency were cited related to the complainvestigation #28182 under 42 Cd 483, Requirements for Long Tentracilities.  483.20(g) – (j) F 278 ASSESSM ACCURACY/COORDINATION FIED  REQUIREMENT: The assessmaccurately reflect the resident's state A registered nurse must conduct of coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and of the assessment is completed.  Each individual who completes a public assessment must sign and certification of the assessment must sign and certification of the assessment is subject to a civil more penalty of not more than \$1,000.00 assessment, or an individual who wand knowingly causes another indicertify a material and false statement resident assessment is subject to a civil more resident assessment is subject to a civil more penalty of not more than \$1,000.00 assessment, or an individual who wand knowingly causes another indicertify a material and false statement resident assessment is subject to a civil more resident assessment is subject t	enplaint d on iencies int CFR Part rm Care  ENT N/CERTI  ent must atus.  or he  certify that  certify that  certify that  contion of fy the essment.  individual fies a esident ney of for each willfully vidual to ent in a civil	
	Clinical disagreemen material and false sta	it does not constitute a atement.		Continue to page 2 of	7	
BORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNA	ATURE	TITLE		(X6) DATE
		0.04	30720	NATION WATER TO THE CONTROL OF THE C		11 14 11

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

## UCU 15 ZU11 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445264 11/30/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 801 E MCKEE ST LAUGHLIN HEALTH CARE CENTER GREENEVILLE, TN 37743 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued from page 1 of 7 F 278 Continued From page 1 F 278 money penalty of not more than \$5,000.00 for each assessment. This REQUIREMENT is not met as evidenced Clinical disagreement does not constitute a by: material and false statement. Based on medical record review and interview the facility failed to ensure accuracy of the POC: Minimum Data Set (MDS) to identify hospice 1. Residents #5 and #7 care plan has been status for two residents (#5, #7) of eighteen updated on November 29, 2011 to residents reviewed reflect that both residents are receiving hospice care. The findings included: 2. The MDS Coordinators working with the Inter-disciplinary Team will Resident #5 was admitted to the facility on continue to revise, correct and update December 20, 2002, with diagnoses including the residents care plan on a scheduled Hypertension and Chronic Obstructive Pulmonary review cycle and as needed based on Disease. ongoing assessments. The Inter-disciplinary Care Plan Team Medical record review of the Minimum Data Set shall meet on at least a scheduled (MDS) dated September 20, 2011, revealed the weekly basis and will systematically resident was not receiving any special review MDS data and care plan treatments, procedures, or hospice care. approaches. The Utilization Committee will also meet at least weekly and will Medical record review of the Hospice Plan of identify hospice residents during that Care dated October 17, 2011, revealed the meeting. resident had received hospice services since 4. An 802 Report will be ran monthly December 21, 2010. under the supervision of the MDS Coordinators to identify all hospice Interview with the MDS Coordinator on November residents. The facility Director of 29, 2011, at 2:48 p.m., in the MDS office, Nursing or designee with the help of the confirmed the MDS assessment failed to indicate Inter-disciplinary Team shall observe the resident was receiving hospice services and for any discrepancies. was inaccurate. December 28, 2011 Resident #7 was re-admitted to the facility on

October 22, 2010, with diagnoses including End Stage Dementia, History of a Cerebral Vascular

Accident, and Stage 3 Kidney Disease.

		HAND HUMAN SERVICES	DEC	1 5 2011		APPROVED
	TRS FOR MEDICARE  OF DEFICIENCIES	& MEDICAID SERVICES		TIPLE CONSTRUCTION	(X3) DATE SI	. 0938-0391
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN		COMPLE	
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LAUGHI	LIN HEALTH CARE CE	ENTER		801 E MCKEE ST GREENEVILLE, TN 37743		
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F 278	Continued From pa	ige 2	F 278			
	November 9, 2011, receiving any special Medical record reviet dated October 12, 2	ew of the MDS dated revealed the resident was not al treatments or hospice care.  ew of a physician's order 2011, indicated the resident is are for End Stage Dementia.	2			
F 323 SS=D	Interview with the D the MDS Coordinate November 30, 2011 MDS was inaccurate to indicate the reside 483.25(h) FREE OF	or in the DON's office on at 8:10 a.m., confirmed the e and had not been updated ent's hospice status.	F 323	483.25(h) F 323 FREE OF ACC HAZARDS/SUPERVISION/DE		
	environment remain as is possible; and e	sure that the resident as as free of accident hazards each resident receives on and assistance devices to		REQUIREMENT: The facility rensure that the resident environme as free of accident hazards as is pound each resident receives adequasupervision and assistance devices prevent accidents.	ent remains ossible,	
	by: Based on medical re and interview, the fac devices were in place of eighteen residents The findings included	d:		<ol> <li>Resident #8 has been reassed bed pad alarm placed on be November 29, 2011.</li> <li>The Interdisciplinary Care I will continue to meet week review and will systematical residents that are care plant alarms.</li> <li>Continue to page 4 of</li> </ol>	ed on  Plan Team  cly to  ally review  ned for	
	21, 2011, with a histo	mitted to the facility on July ory of falls, and diagnoses racture, Anemia, Arthritis,		el el		

		AND HUMAN SERVICES & MEDICAID SERVICES	DEC	C 1 5 2011	FORM	M APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1000	NULTIPLE CONSTRUCTION	(X3) DATE	OMB NO. 0938-039' (X3) DATE SURVEY COMPLETED	
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	(EACH DEFICIENCY	NTER TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	할 때 그리고 하는 하는 것이 없었다. 그 이번 가장 하는 것이 없는 것이 없는 것이 없는 것이 없다.	CORRECTION FION SHOULD BE	(X5) COMPLETION DATE
	Congestive Heart Fa Hypertension.  Medical record reviet August 2, 2011, reveassessed at risk for interventions including member) and gait be ambulationbed alastaff to unassisted risk for interventions including member) and gait be ambulationbed alastaff to unassisted risk Medical record reviet November 17, 2011, "heard resident yel room, resident noted Medical record reviet dated November 17, alarm-not in use"  Interview with the Dir November 29, 2011, office, confirmed the alarm was in place are placement and function.  Resident #13 was add March 10, 2011, with Weakness, Abnormal Degeneration of the Lember 19, dated September 19, dated Septembe	w of the Care Plan dated ealed the resident was falls with care plan ng "assist x1 (one staff elt for transfers and rm on when in bed to alert sing."  w of a nurse's note dated at 5:40 a.m., revealed ling for help. Upon entering lying on floor on right side"  w of a facility investigation 2011, revealed "Bed  ector of Nursing (DON) on at 1:30 p.m., in the DON's facility failed to ensure the nd checked by staff for on.  mitted to the facility on diagnoses including Muscle ity of Gait, and Macular eft Eye.  of the Minimum Data Set per 22, 2011, revealed the on the Brief Interview for	F 3	DEFICIENC	from page 3 of 7 ry Care Plan Team a on the CNA d, where alarms are urs and as needed. gers along with r Team will nt care flow sheets being monitored. December 2  oth side-rails er 30, 2011. gers along with r Care Plan Team ret weeting at least terventions put in eccived during y Care Plan Team et weekly and plans for disciplinary Care rdinate with the ensure that blace. , DON, and nterventions put tt correct	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

DEC 75 ZU11

PRINTED: 12/08/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION  DING		(X3) DATE SURVEY COMPLETED	
		445264	B. WING	G	11/3	30/2011	
	PROVIDER OR SUPPLIER  LIN HEALTH CARE CE	NTER	5	STREET ADDRESS, CITY, STATE, ZIP COD 801 E MCKEE ST GREENEVILLE, TN 37743	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 323	March 22, 2011, an revealed "bruise to siderail on r side of Medical record revie August 2, 2011, revenue purplish bruise to reddened & (and) had climbing OOB (out of	d updated on August 2, 2011, or (right) calf-padding to bed."  ew of a nurse's note dated ealed "resident found (with) calf, skin surrounding bruise is ard. Resident has been of bed) and observed (with) r	F 32	23			
	placed on siderail to areas."  Observations on No p.m., November 30, a.m., in the resident' resident's bed had to on either siderail.  Observation and inte 2011, at 8:58 a.m., v Assistant (CNA) #1,	in the resident's room, nt's siderails were not was unaware of the					
F 441 SS=D	2011, at 9:03 a.m., w Manager, in the resident was to have injury and the siderai 483.65 INFECTION ( SPREAD, LINENS) The facility must esta Infection Control Prog safe, sanitary and con	rview on November 30, with the West Wing Unit lent's room, confirmed the padded siderails to prevent les were not padded. CONTROL, PREVENT leblish and maintain an agram designed to provide a maintable environment and evelopment and transmission	. F 441	483.65 F 441 INFECTION COPREVENT SPREAD, LINEN REQUIREMENT: The facilit establish and maintain an Infect Continue to pag	y must ion Control		

		AND HUMAN SERVICES	DEC	1 5 2011		APPROVE
CENT	ERS FOR MEDICARE	& MEDICAID SERVICES	DEC	1 3 2011		. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		445264	B. WING		1	
NAME OF	PROVIDER OR SUPPLIER	- 440204				30/2011
	ILIN HEALTH CARE CE	NTER	S	RTREET ADDRESS, CITY, STATE, ZIP COD 801 E MCKEE ST	Œ	
(YA) ID	SUMMARY STA	TEMENT OF DESIGNATION		GREENEVILLE, TN 37743		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
-	of disease and infection Control The facility must est Program under which (1) Investigates, confine the facility; (2) Decides what proshould be applied to (3) Maintains a reconactions related to infection (b) Preventing Spread (1) When the Infection determines that a respression that a respression to the spread of isolate the resident. (2) The facility must communicable disease from direct contact will train (3) The facility must in hands after each direct and washing is indicated by the spread of its professional practice. (c) Linens Personnel must hand transport linens so as infection.  This REQUIREMENT by: Based on observation interview, the facility for the spread of the spr	Program cablish an Infection Control ch it - atrols, and prevents infections coedures, such as isolation, an individual resident; and and of incidents and corrective ections.  Independent of the control of the contro	F 44	Continued from Program designed to provide a and comfortable environment a prevent the development and tre disease and infection.  (a) Infection Control Program The facility must establish an In Control Program under which i  (1) Investigates, controls, and infections in the facility;  (2) Decides what procedures, isolation, should be applie individual resident; and  (3) Maintains a record of inci- corrective actions related to  (b) Preventing Spread of Infect (1) When the Infection Control determines that a resident isolation to prevent the sp- infection, the facility must resident.  (2) The facility must prohibit with a communicable dise infected skin lesions form contact with residents or the direct contact will transmit  (3) The facility must require s their hands after each direct contact for which hand wa indicated by accepted prof practice.  (c) Linens Personnel must handle, store, pro transport linens so as to prevent of infection.  Continue to page	safe, sanitary nd to help ansmission of the pansmission of the pansmission of the prevents are down to infections. The program needs are dof the program needs are dof the program needs are down the program direct the program of the program needs are down the progr	
	hand washing techniq	ue with dressing change for		Continue to page	017	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/08/2011

FORM APPROVED

## DEC 1 5 2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 445264 11/30/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 801 E MCKEE ST LAUGHLIN HEALTH CARE CENTER GREENEVILLE, TN 37743 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued from page 6 of 7 F 441 Continued From page 6 F 441 one (#1) of eighteen sampled residents. POC: 1. Resident #1 involved in this incident. The findings included: Treatment Nurse LPN was counseled with review of Policy and Procedure Resident #1 was re-admitted to the facility on for this practice on November 29. October 24, 2011, with diagnoses including Pressure Ulcer, Diabetes, and Chronic 2. The facility's Annual In-service Obstructive Pulmonary Disease. calendar lists infection control protocols including proper hand-Observation of a dressing change on November washing. A mandatory hand-washing 29, 2011, at 10:25 a.m., revealed the Licensed with return demonstration is Practical Nurse (LPN) #1 removed the soiled conducted annually by hospital dressing from the pressure ulcer, cleaned the infection control staff. pressure ulcer with normal saline, and removed 3. An in-service for all licensed the gloves. Observation revealed without personnel directed towards handwashing the hands, the nurse applied new gloves washing before and after use of and proceeded to complete the dressing change. gloves, will be completed before Further observation revealed when the dressing December 28, 2011. change was completed, the nurse removed the The DON, ADON and Wing gloves, placed them in the biohazard bag, and Managers will be responsible for without washing the hands, picked up the direct observations to assure that biohazard bag, and took the bag down the hall to licensed staff are performing handthe biohazard room. The nurse then came back washing between glove changes. to the resident's room and washed the hands. December 28, 2011 Review of facility policy, Handwashing, revealed "...All facility personnel shall wash their hands in the following instances to prevent the spread of infections: Before applying and after removing gloves..." Interview with LPN #1 on November 29, 2011, at 11:30 a.m., in the East Nursing Station. confirmed the the facility's policy for handwashing was not followed during the dressing change.

FINITED. IZ/U0/ZU11